For Office Use Only
DATE STAMP

❑ NEW APPLICATION

❑ RENEWAL APPLICATION

Maryland Department of Health and Mental Hygiene

Maryland Children's Health Program (MCHP)

FOR PREGNANT WOMEN AND CHILDREN UNDER AGE 19 ONLY

Application Instructions:

- ✓ **Complete the application honestly and completely.**
- ✓ **Print all answers clearly.**
- ✓ **Fill in all boxes. If no answer, write "None" in the box.**

1. Tell Us Who You Are And Where You Live.

Last Name (Parent/Guardian)	First Name	M.I (Jr., Sr.)	Home, Work or Cell Phone, or Pager Number	Family's Primary Language:	Marital Status (Circle One): Single, Married, Separated, Divorced, or Widowed

Home Address (Include Apartment/Lot Number)	City	State	Zip Code	Have you ever used another name? ❑ NO ❑ YES If Yes, list other names:
Mailing Address (If Different From Above)	City	State	Zip Code	

2. Tell Us About the People Living in the Household. Check each child or pregnant woman applying for MCHP.

NOTE: Social Security numbers given will not be shared with the Immigration and Naturalization Service (INS).

Are you applying for MCHP for this person? Yes or No	Last Name	First Name	How is this person related to you? (Spouse, child, step-child, grandchild, etc.)	Date of Birth Month Day Year	Sex Male or Female	Are you of Hispanic or Latino origin? Yes or No	Race: Select all that apply: Caucasian, Asian, African-American, Amer-Indian Alaskan-Native, Native Hawaiian, Pacific Islander	Maryland Resident (Permanent or Indefinitely? Yes or No	Social Security Number **Needed for MCHP applicants only.**	U. S. Citizen? Yes or No **Needed for MCHP applicants only.**
☐YES ☐NO			**SELF**		☐ **M** ☐**F**	☐YES☐NO		☐YES ☐NO		☐YES ☐NO ☐Not applying
☐YES ☐NO					☐ **M** ☐**F**	☐YES☐NO		☐YES ☐NO		☐YES ☐NO ☐Not applying
☐YES ☐NO					☐ **M** ☐**F**	☐YES☐NO		☐YES ☐NO		☐YES ☐NO ☐Not applying
☐YES ☐NO					☐ **M** ☐**F**	☐YES☐NO		☐YES ☐NO		☐YES ☐NO ☐Not applying
☐YES ☐NO					☐ **M** ☐**F**	☐YES☐NO		☐YES ☐NO		☐YES ☐NO ☐Not applying

3. Is anyone applying for MCHP in your household pregnant? ☐ YES ☐ NO

Name of Person Who Is Pregnant	Your Due Date (Required To Process This Application)	Single Baby? Twins? Triplets?

4. Tell Us If Anyone Applying For MCHP (Child or Pregnant Woman) Has Any Unpaid Medical Bills For Services Received In The Three (3) Months Prior to the Month of Application. Examples of unpaid medical bills would include doctor's visits, hospitalization, medical tests, prescriptions, equipment, etc.

4A. Do you want MCHP to help with these unpaid bills? ☐ **YES** ☐ **NO**	4B. Tell us who received medical care and when. **Name**	**Month/Year**

5. Tell Us If Anyone Applying For MCHP Has Other Medical Expenses, for which a third party may be responsible. Fill out the following information if anyone applying for MCHP has medical expenses that are a result of an accident, job injury or malpractice, or is expecting to receive an accident settlement, trust fund, inheritance or other money or property.

Name of Injured Person	Date of Accident/Injury
Name and Address of Other Persons or Companies That May Be Responsible	
Money or Property Expected	Name, Address and Telephone No. of Attorney Involved

6. If The Child Applying For MCHP Is Not Eligible For Free Medical Care:

Would you (the parent or guardian of the applicant) be willing to pay $41.00 - $52.00 each month to cover all children in the household for health insurance coverage through MCHP Premium? ☐**YES** ☐ **NO**

7A. Does Anyone Applying For MCHP Have Employer-Based Health Insurance? ☐ **YES** ☐ **NO**

If Yes, answer the following:

Name of Policy Holder _____ Name of Person(s) covered _____
Name

Insurance Company Name _____ Policy Number _____

Group#_____ Effective Date _____ End Date _____

7B. Have you dropped employer-based health insurance coverage for the applicant within 12 months of filing this application for MCHP?
☐YES ☐ NO

If yes, please tell us when and why coverage was dropped: ☐ 0-3 months ☐ 4-6 months ☐ 7-9 months ☐ 10-12 months

☐ Changed Employer ☐ Terminated From Job ☐ Employer dropped coverage ☐ COBRA Coverage Ended ☐ No Longer Needed ☐ Quit Job

☐ Cost ☐ Moved Out of Service Area Of Employer's Health Plans ☐ Dropped Limited Benefit Insurance (Vision, Dental, Not Hospital) ☐ Other: _____

8. Tell Us About Family Income.

A. **Earned Income.** List any wages, tips, commissions, earnings or money from self-employment. **Send proof of income if you did not give Social Security numbers in Question 2.** For child applicants, we count the parents' income for children if living together. We count income from your child's brothers and sisters living in the household if you choose to include them. For pregnant women of any age, we count the pregnant woman's income and the income of her spouse, if married and living together. **We don't count income from other adults in the household (grandparents, aunts, and uncles).**

Name of Employed Person	Name of Employer	Address of Employer Street, City, State, Zip Code	Telephone Number	Gross Amount Paid (before taxes) Each Pay Period	How Often Paid? weekly biweekly monthly 2x monthly quarterly annually	Job Start Date	Job End Date	Student Status (Full or part-time)

B. Unearned Income. List any other income received such as alimony, child support, pension, Social Security, income received from renting property to others and benefits (retirement, strike benefits, unemployment, veterans, workers compensation). Include out-of-state benefits.

Person Receiving Income	Type (For Benefits, Include Claimant ID #)	Gross Amount Received	How Often?

C . If you didn't list any income in 8A. or 8B., how do you get food and shelter?_____

9A. Tell Us If You Pay For Child Care While You Are Working. This expense lowers the amount of income we count and may help you become eligible.

Name of Child Care Provider or Day Care Center	Telephone #	Name(s) of Child(ren) Cared For	Your Cost	Who Pays For This Child?
			$ PER	
			$ PER	
Do you have Purchase of Care Services/Vouchers through the Department of Social Services? ☐ YES ☐ NO				

9B. Tell Us If You Pay Child Support Or Alimony. These expenses lower the amount of income we count and may help you become eligible.

Name of Person In Your Household Who Is Paying Child Support or Alimony	Name of Person Outside Your Household Who Is Receiving These Payments	Amount Paid	How Often?

10. Other Information

The Maryland Children's Health Program would like to know how you found out about our program.	If anyone in your household is not registered to vote, would they be interested in receiving voter registration forms? ☐ YES ☐ NO How Many?_____
☐ Friend ☐ Family ☐ School ☐ Community Organization ☐ Doctor/Health Care Professional ☐ Advertisement ☐ Other _____	☐ ALREADY REGISTERED

--GO TO NEXT PAGE TO SIGN APPLICATION--

Here are your rights and responsibilities under the Maryland Children's Health Program.
Please read these carefully before signing below.

Health Care Benefits I know I have the right to request and, if found eligible, to receive MCHP benefits based on policies and standards established under Maryland law. If I am applying as a pregnant woman, I understand that abortion is not covered.

Confidentiality I understand that the information I have given is confidential. I agree that medical information about my children or me can be released when the law allows.

Social Security Number (SSN) I understand that providing the SSNs of MCHP applicants is required and that providing the social security numbers of other household members and MCHP Premium applicants is voluntary. I will not be penalized if the SSNs of household members who are not applying for MCHP or the SSNs of MCHP Premium applicants are not provided. SSNs will not be shared with Immigration and Naturalization Services (INS), and will only be used to help check the information about income and insurance coverage and to help maintain eligibility files. If I do not have a SSN and want to apply for one, I understand that my case manager will help me.

Personal and Financial Information I agree to the release of personal and financial information from this application form to the agencies determining eligibility. I give permission for officials of the Maryland Children's Health Program to verify all information on this form. I understand I may be asked to provide additional information.

Third Party Payments And Cooperation With Quality Control Review I understand that I am required by law to assign to the State all rights to medical support and other third party payments (hospital and medical benefits) and to cooperate with the State's Medical Assistance quality control review process including verification of all information pertinent to the determination of eligibility.

Reporting Changes I have a responsibility to report all changes that might affect eligibility within ten (10) days of the change. Examples of changes I must report are changes in number of people in the household, address, income, employment and pregnancy. I can report changes in person, by telephone, or by mail to my case manager at my local health department or at the Department of Health and Mental Hygiene.

Rights I know that this application will be considered without regard to race, color, sex, age, handicap, religion, national origin or political belief. I know that I may request a hearing if I believe the State of Maryland in processing my application has made an error or if I feel I have been discriminated against. I have the right to appeal any action taken by the Department. If I ask for a hearing, my case manager can help me put my request in writing. At my hearing, I can speak for myself or have someone else represent me. I have a right to a written notice of all decisions affecting my eligibility.

Please sign this statement.
I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Maryland to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I can be penalized if I knowingly give false information. I certify that the children and pregnant woman for whom I am applying are U.S. citizens or lawful immigrants or are applying for emergency services only.

This application must be signed by a pregnant or post-partum woman of any age, a parent or step-parent living with the child applicant, or an authorized representative aged 21 or over for a child not living with a parent.

Signature:_____ **Date:** _____

_____
PLEASE PRINT NAME